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No. A-590

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ALEXANDER L. STEVENS

Supreme Court of the United States

October Term, 1983

BERGEN PINES COUNTY HOSPITAL,

Appellant,

vs.

**NEW JERSEY DEPARTMENT OF HUMAN SERVICES; ANN
KLEIN, COMMISSIONER; NEW JERSEY DIVISION OF
MEDICAL ASSISTANCE AND HEALTH SERVICES:
THOMAS M. RUSSO, DIRECTOR; NEW JERSEY DIVISION
OF HEALTH ECONOMICS; JAMES HUB, DIRECTOR,**

Appellees.

On Appeal From the Supreme Court of New Jersey

JURISDICTIONAL STATEMENT

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QUESTIONS PRESENTED

1. Did the State of New Jersey in failing to take into consideration the costs of governmental providers of long term health care in promulgating its pre-CARE medicaid reimbursement rates, disregard the federal mandate requiring that medicaid reimbursement be "reasonably cost related," 42 U.S.C. §1396a(a)(13)(E), contrary to the Supremacy Clause of the United States Constitution.

2. Did the state court in not reaching that federal issue in reliance on a state procedural ground, have a proper, adequate, and independent state basis for its decision, where the procedural rules were so vague and indefinite that they defeated the reasonable procedural expectations of the appellant.

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In The
Supreme Court of the United States

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BERGEN PINES COUNTY HOSPITAL,

Appellant,

vs.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES; ANN KLEIN, COMMISSIONER; NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; THOMAS M. RUSSO, DIRECTOR; NEW JERSEY DIVISION OF HEALTH ECONOMICS; JAMES HUB, DIRECTOR,

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JURISDICTIONAL STATEMENT

INTRODUCTION

Bergen Pines County Hospital (hereinafter sometimes "BPCH" or "appellant"), appeals from the final judgment of the Supreme Court of New Jersey (8a) decided on October 24, 1983, and filed with that court on October 26, 1983, which had

refused to overturn a decision of the Superior Court, Appellate Division, dated May 27, 1983 (10a, *et seq.*).

As indicated in the Appellate Division opinion, this matter concerns a claim by BPCH that the State, in establishing its Medicaid reimbursement rates, dramatically under reimbursed appellant for the cost of maintaining its long term care facilities due to the State's failure to comply with the federal mandate contained in 42 U.S.C. §1396a(a)(13)(E) that the regulations be "reasonably cost related," thus violating the supremacy clause of the United States Constitution, U.S. Const., Art. VI, par. 2. In deciding the matter, the Appellate Division of the State of New Jersey, dismissed that part of BPCH's claims relating to the rate period which has come to be known as the "pre-CARE" period (from July 1, 1976, to December 31, 1977), based on a failure of BPCH to meet certain state procedural requirements in presenting its claims. BPCH is appealing only that part of Appellate Division's decision which dismissed those pre-CARE claims. The post December 31, 1977, "CARE" claims are still pending before the New Jersey Supreme Court.

A timely notice of appeal was filed with the Supreme Court of New Jersey on January 20, 1984, (6a) and an application for extension of time to docket appeal was made to, (2a) and granted by, (1a) the Hon. William J. Brennan, Jr. extending the time within which to docket up to and including February 22, 1984.

OPINIONS BELOW

The Supreme Court of New Jersey's order to the Appellate Division is attached hereto as 8a. It is as yet unreported.

The decision of the Appellate Division is attached as 10a, and has not been published.

JURISDICTION

The appellate jurisdiction of this Court is based on 28 U.S.C. §1257(2) in that the state court, in dismissing the federal challenge to the state law on a state procedural ground, made a "decision *** in favor of its validity" and thus appealable as of right. See, e.g., *Lawrence v. State Tax Comm'n*, 286 U.S. 276, 282 (1932); see generally Hart & Wechsler, *The Federal Courts and the Federal System*, 642-643 (2d ed. 1973). In the alternative, jurisdiction would be based on 28 U.S.C. §1257(3) in that in addition to the underlying federal question, the question as to whether defaults in compliance with state procedural rules can preclude consideration by the United States Supreme Court of a federal question, is itself a federal question. *Henry v. Mississippi*, 379 U.S. 443, 446-47 (1965); see, generally Hill, "The Inadequate State Ground," 65 Colum. L. Rev. 943 (1965). Should the Court decide that the matter is better cast as a petition for a writ of certiorari, see 28 U.S.C. §2103, then BPCH respectfully requests that the matter be considered as the same.

CONSTITUTIONAL PROVISIONS, STATUTES, RULES AND REGULATIONS

United States Constitution

U.S. Const. Art. VI., par. 2,

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const., Amend. XIV, Sec. 1, cl. 2

***nor shall any state deprive any person of life,
liberty, or property, without due process of law.

United States Code

42 U.S.C. §1396a(a)(13)(E) (Law. Co-op. 1973)

§1396a. State plans for medical assistance

(a) Contents. A State plan for medical assistance must—

• • •

(13) provide—

• • •

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary;

• • •

(19) such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients;

Code of Federal Regulations

Reasonable Cost-Related Basis for Long-Term Care Facility Services, 42 C.F.R. §447.272 (1977)

Definitions

For the purposes of §§450.271-450.316—

“Long-term care facility services” means skilled nursing care facility services and intermediate care facility services.

“Provider” means a provider of skilled nursing facility or intermediate care facility services.

42 C.F.R. §447.273 (1977)

The medicaid agency must pay for long-term care facility services on a reasonable cost-related basis in accordance with §§447.274 through 447.311.

42 C.F.R. §447.302 (1977)

Actual costs

(a) Methods and standards for determining payment rates must reasonably take into account actual costs of the allowable items set forth in §§447.278 through 447.284, reported under §447.274 and as verified by audits under §§447.292 and 447.293.

(b) Payment rates must not be set lower than rates that the agency reasonably finds to be adequate to reimburse in full the actual allowable costs of a facility that is economically and efficiently operated.

New Jersey Statutes Annotated

N.J. Stat. Anno. §30:4D-1 et seq. (West 1981)

Short title

This act shall be known and may be cited as the "New Jersey Medical Assistance and Health Services Act." L. 1968, c. 413, §1.

N.J. Stat. Anno. §30:4D3(h) (West 1981)

Definitions

As used in this act, and unless the context otherwise requires:

• • •

h. "Provider" means any person, public or private institution, agency or business concern approved by the division lawfully providing medical care, services, goods and supplies authorized under this act, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

N.J. Stat. Anno. §30:4D-6(a), (c) (West 1981)

Basic medical care and services

a. Subject to the requirements of Title XIX of the Federal Social Security Act,¹ the limitations imposed by this act and by the rules and regulations promulgated pursuant thereto, the department shall provide medical assistance to qualified applicants including authorized services within each of the following classifications:

- (1) Inpatient hospital services;
- (2) Outpatient hospital services;
- (3) Other laboratory and X-ray services;

(4)(a) Skilled nursing or intermediate care facility services;

(b) Such early and periodic screening and diagnosis of individuals who are eligible under the program and are under age 21 to ascertain their physical or mental defects and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary of the Federal Department of Health, Education and Welfare and approved by the commissioner;

(5) Physicians' services furnished in the office, the patient's home, a hospital, a skilled nursing or intermediate care facility or elsewhere.

c. Payments for the foregoing services, goods and supplies furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto and, where applicable, subject to the agreement of insurance provided for under this act. Said payments shall constitute payment in full to the provider on behalf of the recipient. Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, his family, his representative or others on his behalf for the services, goods and supplies furnished pursuant to this act.

No provider whose claim for payment pursuant to this act has been denied because the services, goods or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on his behalf for such services, goods, and supplies provided pursuant to this act; provided, however, a provider may seek reimbursement from a recipient for services, goods or supplies not authorized by this act, if the recipient elected to receive the services, goods or supplies with the knowledge that they were not authorized.

N.J. Stat. Anno. 30:4D-7 (West 1981)

Duties of commissioner

The commissioner is authorized and empowered to issue, or to cause to be issued through the Division of Medical Assistance and

Health Services all necessary rules and regulations and administrative orders, and to do or cause to be done all other acts and things necessary to secure for the State of New Jersey the maximum Federal participation that is available with respect to a program of medical assistance, consistent with fiscal responsibility and within the limits of funds available for any fiscal year, and to the extent authorized by the medical assistance program plan; to adopt fee schedules with regard to medical assistance benefits and otherwise to accomplish the purposes of this act, including specifically the following:

e. To assure that any applicant, qualified applicant or recipient shall be afforded the opportunity for a hearing should his claim for medical assistance be denied, reduced, terminated or not acted upon within a reasonable time;

Rules Governing the Courts of the State of New Jersey

Pressler, Current N.J. Court Rules, R. 1:1-2

Construction and Relaxation

The rules in Part I through Part VIII, inclusive, shall be construed to secure a just determination, simplicity in procedure, fairness in administration and the elimination of unjustifiable expense and delay. Unless otherwise stated, any rule may be relaxed or dispensed with by the court in which the action is pending if adherence to it would result in an injustice. In the absence of rule,

the court may proceed in any manner compatible with these purposes.

Note: Source—R.R. 1:27A, 3:1-2, 3:11-9, 4:1-2, 4:121, 6:1-1 (second sentence), 6:1-2, 8:1-2. Amended June 20, 1979 to be effective July 1, 1979.

Pressler, Current N.J. Court Rules, R. 2:2-1

Appeals to the Supreme Court from Final Judgments

(a) As of Right. Appeals may be taken to the Supreme Court from final judgments as of right: (1) in cases determined by the Appellate Division involving a substantial question arising under the Constitution of the United States or this State; (2) in cases where, and with regard to those issues as to which, there is a dissent in the Appellate Division; (3) directly from the trial courts in cases where the death penalty has been imposed and in post-conviction proceedings in such cases; (4) in such cases as are provided by law.

(b) On Certification. Appeals may be taken to the Supreme Court from final judgments on certification to the Appellate Division pursuant to R.2:12.

Pressler, Current N.J. Court Rules, R. 2:2-3(a)(2)

Appeals to the Appellate Division from Final Judgments, Decisions, Actions and from Rules; Tax Court

(a) As of Right. Except as otherwise provided by R.2:2-1(a)(3) (final judgments appealable directly to the Supreme Court), appeals may be taken to the Appellate Division as of right

* * * *

(2) to review final decisions or actions of any state administrative agency or officer, and to review the validity of any rule promulgated by such agency or officer excepting matters prescribed by R.8:2 (tax matters) and matters governed by R.4:74-8 (Wage Collection Section appeals), except that review pursuant to this subparagraph shall not be maintainable so long as there is available a right of review before any administrative agency or officer, unless the interest of justice requires otherwise;

Pressler, Current N.J. Court Rules, R. 2:4-1(b)

Time: From Judgments, Orders, Decisions,
Actions and from Rules

(b) Appeals from final decisions or actions of state administrative agencies or officers, other than appeals from judgments of the Division of Workers' Compensation and other than those governed by R.8:2 (tax matters) and by R.4:74-8 (Wage Collection Section appeals), shall be taken within 45 days from the date of service of the decision or notice of the action taken.

Pressler, Current N.J. Court Rules, R. 2:12-4

Grounds for Certification

Certification will be granted only if the appeal presents a question of general public importance which has not been but should be settled by the Supreme Court or is similar to a question presented on another appeal to the Supreme Court; if the decision under review is in conflict with any other decision of the same or a higher court or calls for an exercise of the Supreme Court's supervision and in other matters if the interest of justice requires. Certification will not be allowed on final judgments of the Appellate Division except for special reasons.

Pressler, Current N.J. Court Rules, R. 2:12-9

Where Party Appeals and at the Same Time Makes Application for Certification

Where a party seeks certification to review a final judgment of the Appellate Division and also appeals therefrom, he shall state in the petition for certification all questions he intends to raise on the appeal. The denial of certification shall be deemed to be a summary dismissal of the appeal, and the Clerk of the Supreme Court shall forthwith enter an order dismissing the appeal, unless the Supreme Court otherwise orders.

RAISING THE FEDERAL QUESTION

At the commencement of the action, indeed within the initial pleading before the Appellate Division, the appellant raised the claim that the State of New Jersey in promulgating its standards

of medicaid reimbursement violated the federal mandate that the same be "reasonably cost related" pursuant to 42 U.S.C. § 1396a(a)(13)(E),¹ contrary to the Supremacy Clause of the United States Constitution, U.S. Const. Art. VI, par. 2, as, *inter alia*, appellant's costs and the costs of other governmental institutions had not even been considered in the state's calculations of the pre-CARE rates of reimbursement. The Appellate Division and New Jersey Supreme Court, in failing to consider these federal claims, at that time gave rise to the additional federal questions as to whether or not its failure to do so was based on an adequate and independent state procedural ground or whether the same improperly prevented assertion of federal rights.

STATEMENT OF THE CASE

This matter concerns a claim by a governmental hospital, Bergen Pines County Hospital, appellant, that the State has failed to properly reimburse it for its expenses in operating its hospital based, long term care facilities. The claim is primarily predicated upon the state's purposeful failure to consider data on costs submitted by BPCH and others similarly situated in computing the New Jersey Medicaid reimbursement rates. Appellant contends that because of this decision, the reimbursement rates failed to be "reasonably cost related" as mandated by federal law, 42 U.S.C. §1396a(a)(13)(E) and contract.

BPCH filed the action on November 17, 1980 in the Appellate Division of New Jersey's Superior Court pursuant to R. 2:2-3(a)(2)

1. The statute has since been amended, to require that state plans provide reimbursement " * * * reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities * * *". 42 U.S.C. §1396a(a)(13)(A). The revision specifically orders the states to " * * * take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs * * *". *Id.*

as it was a challenge to the improper actions of the state agencies. Briefly stated, appellant's claims were:

1. a challenge to the reimbursement rates set for BPCH for the period July 1, 1976 to December 31, 1977 ("Pre-CARE period");

2. a challenge to the reimbursement rates set for the period from January 1, 1978 to the present ("CARE period");

3. as, pursuant to federal law, providers of long term care who participate in the State Medicaid program must enter into "provider agreements" with the State, correlative claims that the State failed to reimburse BPCH on a "reasonable cost related" basis as mandated by contract.

4. pendant claims for individual adjustments to the rates, should BPCH's claims prove unsuccessful.

The Parties

The parties and their respective roles in that proceeding were as follows:

1. Appellant Bergen Pines County Hospital, is a multi-service, governmental health care institution and a provider of long term medical care within the meaning of 42 C.F.R. §447.272 and N.J.S.A. 30:4D-3(h), operating a hospital-based long term medical care facility (or home) consisting of over 625 beds.

2. Appellees are various state officials and departments who are charged under New Jersey law with the development and administration of the New Jersey Medical Assistance and Health Services Act (Medicaid). N.J.S.A. 30:4D-1 et seq. Unless otherwise indicated they will be collectively referred to as the "State" or "appellees".

The "Pre-CARE" System

In 1972, Congress amended Title XIX of the Social Security Act to require that a state plan for long-term health care assistance provide "... for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost-related basis. . . ." See Social Security Amendments of 1972, Section 249a, 42 U.S.C. §1396a(a)(13)(E); *see also*, N.J.S.A. 30:4D-6(a). This provision was to take effect July 1, 1976. 42 U.S.C. §1396a(a)(13)(E). These "state plans" were to be developed by state agencies "... on the basis of cost finding methods approved and verified . . ." by the Secretary of Health, Education and Welfare (hereinafter sometimes "HEW"). *Id.* Indeed, the federal government was to provide one-half of all the funding for these programs. 42 U.S.C. §1396(a). HEW, now the United States Department of Health and Human Services (hereinafter sometimes HHS), subsequently issued various regulations which also insisted upon a "reasonable cost-related basis" for reimbursement. 45 C.F.R. §250.30(a)(3), recodified at 42 C.F.R. §447.273. Moreover, the federal regulations provide that the state plan must take into consideration actual costs and must not result in payment rates "lower than rates that the agency reasonably finds to be adequate to reimburse in full the actual, allowable costs of a facility that is economically and efficiently operated." 42 C.F.R. §447.302.

In response to this federal requirement that the amount of reimbursement a health care provider receives under Medicaid be reasonably related to the actual cost in providing that service,

the state through Human Services (then the Department of Institutions and Agencies) and Medical Assistance, began to develop "The New Jersey Medicaid Reimbursement System." This system was placed into effect on July 1, 1976 and was applied to BPCH during two definable rate periods:

(1) from July 1, 1976 to June 30, 1977; and

(2) from July 1, 1977 to December 31, 1977.

These guidelines have generally become known in relation to their present day successor. That method is entitled the "Cost Accounting Rate Evaluation" System (or "CARE") and thus, the pre-January, 1978 methodology is known as the "Pre-CARE" system.²

In setting the pre-CARE rates, the respondents, Human Services and Medical Assistance, as well as their respective respondent administrators, established a rate-setting process which categorized facilities by bed size and location prior to "screening" costs for reasonableness. Thereafter, they established a payment rate based on a per-patient day or "per diem." This was calculated by identifying various cost centers or cost classifications necessary to the functioning of a long-term care facility. The average, daily cost per patient was established by gathering information with respect to these cost centers from various skilled nursing facilities throughout the state. However, a conscious decision was made to exclude from this "representative" or "median" group from which the daily rate would be established, the largest provider of a long-term Medicaid services in the state, that is, county and state governmental institution of which plaintiff, BPCH, is one.

2. The New Jersey Medicaid reimbursement system, in effect from July 1, 1976 to December 31, 1977 was not codified and the pertinent part is attached as 17a, *et seq.*

The reason for the exclusion of the "governmentals," although never specifically stated at the time, was obviously because if the governmentals, with their concededly higher costs were considered in setting the rates, then the State's reimbursement cost would be commensurately higher.

The Claim

It is the basic contention of petitioner that as a result of failing to either take the governmental institutions into consideration within the median groups, or to separately group the governmental institutions for purposes of establishing a "governmental" per diem rate, the Pre-CARE Medicaid reimbursement system failed to be "reasonably cost related" as mandated by the federal government. Some of the major issues which resulted in the large discrepancies between the actual BPCH per diem rate and the State per diem rate as follows:

(a) As private hospitals refuse them, and due to the hospital setting, BPCH has the largest number of severely handicapped patients which require innumerable more nursing hours and greater costs;

(b) Appellant has certain uncontrollable costs activated by its status as a governmental entity;

(c) Its patient-mix requires more services which can only be obtained at a multi-service, i.e., hospital based facility;

(d) Because the skilled nursing facility is only a part of this multi-service medical center the cost allocation methods employed do not reasonably relate to the actual costs incurred. The methodology deals with a "per diem basis" while BPCH incurs fixed unit costs (e.g., incurring per diem costs of sending out laundry vs. the fixed unit costs of operating an inhouse laundry).

Of course, as BPCH is prohibited from charging its Medicaid patients the extra cost, N.J.S.A. 30:4D-6(c), the extra cost is absorbed by the hospital. This failure to properly take into account these governmental providers' costs for the period July 1, 1976 through December 31, 1977, resulted in a loss to appellant of approximately \$4,330,000 or, in other words, appellant was only being reimbursed approximately 60% of its actual costs for this pre-CARE period.

In light of the above dramatic under reimbursement, BPCH sought a review of the guidelines. However, there was no formal appeal process for administratively addressing the pre-CARE rate structure. See 17a to 40a. Pursuant to the pre-CARE guidelines, (39a to 40a), representatives of BPCH contacted various governmental officials on numerous occasions and were informed that the hospital was entitled to an administrative hearing after finalization of the appellees' Medicaid audit of appellant's facility. This Medicaid audit was not undertaken until May of 1979. BPCH had filed all necessary "cost analysis"; but at the time of its initial filing up to the point of the oral argument of the appeal, BPCH had not received any finalization of its rate. BPCH maintained that it could only appeal a "final decision, or action," R. 2:4-1(b); and it could only receive a final decision and rate from which to appeal when that audit was finished. Appellant contended that it was the State who had unreasonably delayed the matter and, if anything, appellant's pre-CARE appeal was premature and not untimely.

Appellate Division

Before the Appellate Division of the Superior Court BPCH urged several points:

- (1) that procedurally the State had failed to obtain proper approvals and follow proper federal rules in administering the program;

- (2) that other states had reviewed the disproportionate financial burdens of governmental and hospital based nursing institutions and had found reimbursement methods which had failed to take the same into account not "reasonably cost related;"
- (3) the failure to adequately reimburse BPCH was having a tremendous impact on the services being provided both the Medicaid and non-Medicaid patient population as it was limiting the funds available to the appellant to carry out its functions.

The Appellate Division, however, never confronted the issue as to whether or not the pre-CARE system met federal requirements. Rather the court held, in its May 27, 1983 per curiam opinion, that the claims were time barred:

BPCH was informed of its final per diem reimbursement rates under the pre-CARE system on July 29, 1976. These rates represented the maximum amounts permissible under the system for a nursing home of BPCH's size and location; BPCH's reported costs were substantially higher in each expense category. BPCH did not appeal the setting of these rates; however, on December 8, 1977, it requested a hearing before DMAHS on the question whether these rates represented an economic hardship to BPCH. DMAHS responded on January 4, 1978 that BPCH was receiving the maximum reimbursement permitted under the existing system, and therefore was not entitled to relief. BPCH apparently sought no further review of this decision (12a).

(July 29, 1976 letter is attached as 41a; December 8, 1977 letter as 43a; January 4, 1978 letter as 45a.)

As such, the Court held that the pre-CARE rates were long out of time, and should have been appealed to the Appellate Division within 45 days of July 29, 1976 or, at the very least, within 45 days after it had been informed of the state's unwillingness to provide greater reimbursement by the January 4, 1978 letter pursuant to R. 2:4-1(b). In this manner, the pre-CARE claims were dismissed.

The CARE appeal, both the individual BPCH claims and the challenge to that rate structure, was remanded to the Department of Health for supplemental proceedings. The Appellate Division retained jurisdiction. *Id.* BPCH filed a timely petition to the Appellate Division for a partial rehearing pursuant to R. 2:11-6 as to the dismissal of the pre-CARE claims. The State filed a petition for rehearing *nunc pro tunc* of the Appellate Division's decision concerning the CARE appeal. Both petitions were denied.

New Jersey Supreme Court

A timely petition for certification and notice of appeal were thereafter filed by BPCH before the New Jersey Supreme Court concerning the pre-CARE dismissal. The State sought leave to appeal the Appellate Division's CARE rulings.

Before the New Jersey Supreme Court appellant argued that the matter was one of appeal in that it involved " * * a substantial question arising under the Constitution of the United States" as the State's system of Medicaid reimbursement had violated the Supremacy Clause, U.S. Const., Art. VI, par. 2 and that the matter was independently ripe for review by certification under R. 2:12-4. More specifically, BPCH claimed that the Appellate Division's elimination of over \$4,000,000 worth of claims was a matter of general public importance. Appellant argued that although the

July 29, 1976 letter from the State to BPCH indicated that the rates were "final", the letter also states "These rates are subject to a future on-site audit." (41a). There is no indication in the letter of an appeal process to be pursued. In fact, the second page of that letter indicates that "any questions regarding these rates should be referred to *** (the) Bureau of Audits," (42a), further evidencing that the audit itself would actually finalize these rates. It is not questioned that the pre-CARE period had no formal rate review structure, and the guidelines themselves noted the central role of the Bureau of Audits in the regard (40a). Not only was there no Departmental review process, but there was no Office of Administrative Law at that time to which one could seek administrative review.

It is in this context that, when this audit was finally scheduled one year and a half later, BPCH requested a fair hearing (43a). BPCH recognizes that the State at the time was maintaining that " * * * the purpose of the audit is not to establish per diem reimbursement rates." (45a). However, again that reply must be viewed in the context of the prior meetings and requests. Of course, "the purpose of this audit is not to establish per diem reimbursement rates." The purpose of the audit was to confirm the accuracy of the underlining cost studies, and thus, to provide a common basis for negotiation or appeal. If this was not the case then why did not the State either 1) respond to BPCH's request for a hearing immediately and grant the same or 2) object outright to appellant's request for a hearing and inform BPCH to seek redress in the courts? BPCH was left with the impression that before it could receive its fair hearing to challenge the rates and thereafter pursue subsequent appeals, it would have to first have that audit completed. It is only because of the great delay in completing the audit that BPCH filed its appeal believing that the State had had more than a "reasonable time" to review the matter and finalize the rates. See N.J.S.A. 30:4D-7(e). BPCH argued that New Jersey courts had made provisions where

extraordinary circumstances, surrounding issues of public importance, justified an appellate court's waiver of procedural contentions. *Alberti v. Civil Service Comm'n.*, 495 A. 2d 297, 41 N.J. 147 (1963); *Cervase v. Kawaida Towers, Inc.*, 308 A. 2d 477, 124 N.J. Super. 547, 569 (Law and Ch. Div. 1973), *aff'd*. 322 A. 2d 477, 129 N.J. Super. 124 (App. Div. 1974); *Franklin Tp. v. Bd. of Ed. N. Hunterdon Reg. High Sch.*, 378 A. 2d 218, 74 N.J. 345, 348, *cert. denied*, 435 U.S. 950 (1977). See also R. 1:1-2 permitting waiver of limitation on appeal rule (as well as any rule) where injustice would result.

Next, appellant contended that at least questions of fact would be raised as to the status of the audit in the rate setting process and appellant's reliance on the audit to justify a full scale hearing on that issue prior to invoking a procedural rule that would so severely limit federal rights. *Cf.*, *Lopez v. Swyer*, 300 A.2d 573, 62 N.J. 267 (1973) (questions as to discovery of cause of action gave rise to hearing on applicability of statute of limitations). This was especially so as appellant contended that at least a *prima facie* case had been established by the fact that concededly, there had been no review of the State's pre-CARE plan as required by federal law. 42 U.S.C. §1396a(a)(13)(e); see *California Hospital Assoc. v. Obledo*, 602 F. 2d 1357, 1361 (9th Cir. 1979).

Finally, BPCH argued that the court below had erred in applying its own rule, as R. 2:4-1(b) places a time limit for seeking review of decisions and actions of state administrative adjudications and not to quasi-legislative action by administrative agencies such as the promulgation of rules. Compare *McKenna v. N.J. Highway Authority*, 116 A. 2d 29, 19 N.J. 270 (1955) with *Burlington Food Stores, Inc. v. Hoffman*, 195 A. 2d 913, 82 N.J. Super. 452 (App. Div. 1964) (contrasting "quasi-legislative" versus "quasi-judicial" actions of state administrative agencies).

The Supreme Court of New Jersey, however, rejected appellant's claims, both dismissing the appeal and denying the certification (8a), R. 2:12-9, although granting the State's request for leave to appeal the CARE related decisions. BPCCH filed a timely notice of appeal of the pre-CARE dismissal (6a) and received permission for some additional time to docket the same with the Supreme Court of the United States (1a).

THE QUESTION IS SUBSTANTIAL

The underlying federal question in this appeal as to whether or not New Jersey's pre-CARE system was "reasonably cost related" as mandated by federal law is substantial. Congress established the Medicaid system to meet the needs of low income and indigent Americans for health care services. The dramatic under reimbursement of appellant negatively impacts on that federal entitlement, for as BPCCH begins to feel the economic squeeze, so do its Medicaid patients who must contend with cutbacks in beds and services. Federal Law mandates that a state must administer its plan "... in the best interests of the recipients". 42 U.S.C. §1396a(a)(19). A system of reimbursement which persistently discriminates against the appellant, cannot thus be in the "best interests of the recipients" of Medicaid assistance.

There is a negative impact on the non-Medicaid public as well. To quote New Jersey Supreme Court Justice Morris Pashman, in considering a similar problem:

... we cannot ignore the real impact upon the public of denying reimbursement. To the extent that a hospital is not recompensed for services rendered, it will have to absorb the cost itself. This in turn will compel the hospital to pass on these unreimbursed costs to the non-indigent persons who utilize its facilities [sic]. Thus, the costs of

providing for the indigent will be borne solely by those unfortunate enough to require hospital care, rather than being spread among state and national taxpayers. In our opinion, it is more just and equitable to spread the costs. [*Monmouth Medical Center v. State*, 403 A. 2d 487, 80 N.J. 299, 312 (1979)].

Thus, appellant's claims substantially impact not only on the federal entitlements of the poor but on the just and equitable distribution of costs which the federal government has mandated should be spread throughout the nation.

However, perhaps the more interesting and important federal consideration is the threshold question as to what procedural barriers established by the state will defeat the claim of a federal right. As this honorable court stated, over sixty years ago:

Whatever springes the State may set for those who are endeavoring to assert rights that the State confers, the assertion of federal rights, when plainly and reasonably made, is not to be defeated under the name of local practice. . . . [I]t is necessary to see that local practice shall not be allowed to put unreasonable obstacles in the way. [*Davis v. Wechsler*, 263 U.S. 22, 24-25 (1923)].

The Court has struggled throughout its history to define the parameters under which it will intervene in such situations. See generally, Hill, "The Inadequate State Ground," 65 Colum. L. Rev. 943 (1965).

The Court has more recently stated that a procedural default under state law by one pursuing a federal claim will be excused if that rule does not substantially serve a legitimate state purpose.

Henry v. Mississippi, supra, 379 U.S. at 446. Appellant's contention is not that R. 2:4-1(b), standing by itself, fails to serve a legitimate state purpose. The state has an interest in establishing periods of time from which a litigant is to act to appeal final judgments. Appellant's contention is that the court below erred in invoking this rule in this circumstance because the guidelines set by the State appellees concerning (1) the steps to be taken by the appellant and (2) as to what constituted a final judgment, were so vague and indefinite as to defeat the reasonable procedural expectations of the appellant. As indicated above, the State did not establish any timetable within which to challenge the pre-CARE guidelines but merely stated that should there be any questions regarding the same, the appellant should contact two designated officers and the Bureau of Audits (39a-40a). It was just this vague procedure which led to the misunderstandings between the parties as to when a "final decision" as to the pre-CARE rate would be established, which could then be appealed pursuant to the R. 2:4-1(b).

Federal rights should not be defeated where state procedural standards are so uncertain. In this regard, *NAACP v. Alabama ex rel. Patterson*, 357 U.S. 449 (1958) is instructive. In *NAACP*, the state courts had given confusing and inconsistent indications as to the state procedural alternatives to be followed in raising federal constitutional issues. Before the Court, the state attempted to reconcile old and new law to form a consistent pattern. However the Supreme Court ruled:

... such a local procedural rule, *although it may now appear in retrospect to form part of a consistent pattern of procedures to obtain appellate review*, cannot avail the state here, because petitioner could not fairly be deemed to have been apprised of its existence. Novelty in procedural requirements cannot be permitted to thwart review

in this Court applied for by those who, in justified reliance upon prior decisions, seek vindication in state courts of their federal constitutional rights. Cf., *Brinkerhoff-Faris Co. v. Hill*, 281 U.S. 673. [*Id.* at 457-58].

Similarly the appellant in the instant matter had been given ambiguous indications as to how it was to proceed. Even if appellant had been incorrect in its assumptions, where the standards as to establishing the final rate to appeal where so uncertain, appellant's procedural default should not be deemed to defeat the federal right.

In the alternative, the courts below should, at the very least, have provided some sort of a hearing as to the reasons for the claimed procedural default. Such a procedure was available under New Jersey law. See *Lopez v. Swyer, supra*. Failing to obtain this minimal inquiry, is such a disregard of substantial federal rights as to be a violation of federal due process, U.S. Const. Amend. XIV, Sec. 1, cl. 2, which is, in and of itself, another substantial federal issue.

Finally, should the Court consider this appeal to be more properly a matter for discretionary review, then certiorari should be granted based on the above discussion for the state court, by invoking its procedural rule in a situation where the state's guidelines for appeal were so ambiguous, has decided an important federal question which has not been, but should be, settled by this Court and is contrary to the spirit of the *NAACP* case. See United States Supreme Court Rule 17; see also, 28 U.S.C. §1257(3).

CONCLUSION

This appeal presents the Court with an important opportunity to further define the scope of Supreme Court review of federal matters not reached by state courts due to procedural grounds. For the aforementioned reasons, the Court is respectfully requested to note probable jurisdiction of this appeal, or, in the alternative, to grant certiorari.

Respectfully submitted,

LOUIS L. D'ARMINIO

BRESLIN, HERTEN &
LEPORE, P.C.

Attorneys for Appellant

1a

APPENDIX

**ORDER OF THE SUPREME COURT OF THE UNITED
STATES EXTENDING TIME DATED JANUARY 24, 1984**

**SUPREME COURT OF THE UNITED STATES
No. A-590**

BERGEN PINES COUNTY HOSPITAL,

Appellant,

v.

**NEW JERSEY DEPARTMENT OF HUMAN SERVICES, ET
AL.**

**UPON CONSIDERATION of the application of counsel for
the appellant,**

**IT IS ORDERED that the time for docketing an appeal in
the above-entitled cause be, and the same is hereby, extended to
and including February 22, 1984.**

**s/ William J. Brennan
Associate Justice of the Supreme
Court of the United States**

**Dated this 24th
day of January, 1984.**

**APPLICATION FOR EXTENSION OF TIME TO DOCKET
APPEAL FILED JANUARY 21, 1984**

**IN THE
SUPREME COURT OF THE
UNITED STATES**

OCTOBER TERM, 1983

NO.

BERGEN PINES COUNTY HOSPITAL,

Appellant,

v.

**NEW JERSEY DEPARTMENT OF HUMAN SERVICES; ANN
KLEIN, COMMISSIONER; NEW JERSEY DIVISION OF
MEDICAL ASSISTANCE AND HEALTH SERVICES;
THOMAS M. RUSSO, DIRECTOR; NEW JERSEY DIVISION
OF HEALTH ECONOMICS; JAMES HUB, DIRECTOR,**

Appellees.

**TO: Honorable William J. Brennan, Jr.
Associate Justice of the Supreme Court
of the United States
Circuit Justice for the Third Circuit**

**Application is here made, pursuant to Rule 12.2 for a 30
day extension of time, to and including February 22, 1984, for
the appellant, Bergen Pines County Hospital (BPCH) to docket
the case on appeal to this honorable Court. The final judgment
of the Supreme Court of New Jersey in this matter was decided**

Application for Extension of Time

on October 24, 1983, and filed with that Court on October 26, 1983. The time for docketing the case on appeal, unless extended, and allowing one day for Sunday, will expire on January 23, 1984.

A copy of the judgment appealed from is attached as Exhibit A. The opinion of the Court below is attached as Exhibit B. The Notice of Appeal is filed this date with the Clerk of the Supreme Court of New Jersey, Hughes Justice Complex, Trenton, New Jersey, and is attached as Exhibit C.

As indicated in the opinion, this matter concerns a claim by BPCH that the State, in establishing its Medicaid reimbursement rates, dramatically under reimbursed the Hospital for the cost of maintaining its long term care facilities due to the State's failure to comply with the federal mandate contained in 42 U.S.C. §1396(a)(E) that the regulations be "reasonably cost related," thus violating the supremacy clause of the United States Constitution, U.S. Const., Art VI, par. 2. In deciding the matter, the Appellate Division of the State of New Jersey, dismissed that part of BPCH's claims relating to the rate period which has become to be known as the "PRE-CARE" period, based on a failure of BPCH to meet certain state procedural requirements in presenting its claims.

The appellate jurisdiction of this Court is based on 28 U.S.C. §1257(2) in that the State Court, in dismissing the federal challenge to the state law on a state procedural ground, made a "decision *** in favor of its validity" and thus appealable as of right. See, e.g., *Lawrence v. State Tax Comm'n*, 286 U.S. 276, 282 (1932); see generally Hart & Wechsler, *The Federal Courts and the Federal System*, 642-643 (2nd ed. 1973). In the alternative, jurisdiction would be based on 28 U.S.C. §1257(3) in that in addition to the underlying federal question, the question as to whether defaults

Application for Extension of Time

in compliance with state procedural rules can preclude consideration by the United States Supreme Court of a federal question, is itself a federal question. *Henry v. Mississippi*, 379 U.S. 443 (1965); see generally A. Hill, "The Inadequate State Ground," 65 *Columbia L. Rev.* 943 (1965). Should the Court decide that the matter is better cast as a petition for a writ of certiorari, see 28 U.S.C. §2103, then BPCH respectfully requests that the matter be considered the same, and this application be considered an extension of time to file a petition for writ of certiorari, under Rule 20.6.

Appellant needs additional time due to the fact that the decision to seek further review has only recently been made and missed communications between representatives of the BPCH and counsel prevented that decision from being communicated so as to allow adequate time to meet the Court's requirements as to proper preparation of the jurisdictional statement. The Notice of Appeal itself is timely filed and the appellant begs the Court's indulgence to permit it to be docketed, especially in light of the considerable degree of under reimbursement this taxpayer-supported county hospital is claiming.

My adversary has kindly consented to this extension.

WHEREFORE, it is requested that the time for docketing the case on appeal be extended up to and including February 22, 1984.

Application for Extension of Time

Respectfully submitted,

BRESLIN, HERTEN and
LePORE, P.C.

Attorneys for Appellant

By: Louis L. D'Arminio
LOUIS L. D'ARMINIO

14 Washington Place
Hackensack, New Jersey 07601
(201) 343-5678

NOTICE OF APPEAL FILED JANUARY 20, 1984

**IN THE SUPREME COURT
OF THE STATE OF NEW JERSEY**

SEPTEMBER TERM, 1983

No. 21,488

BERGEN PINES COUNTY HOSPITAL,

Petitioner-Appellant,

v.

**NEW JERSEY DEPARTMENT OF HUMAN SERVICES; ANN
KLEIN, COMMISSIONER; NEW JERSEY DIVISION OF
MEDICAL ASSISTANCE AND HEALTH SERVICES;
THOMAS M. RUSSO, DIRECTOR; NEW JERSEY DIVISION
OF HEALTH ECONOMICS; JAMES HUB, DIRECTOR,**

Respondents-Respondents.

Notice is hereby given that Bergen Pines County Hospital, the appellant above named, hereby appeals to the Supreme Court of the United States from the final judgment of the Supreme Court of the State of New Jersey on October 24, 1983, denying appellant's petition for certification and dismissing appellant's appeal of the Appellate Division's May 27, 1983, decision dismissing appellant's pre-CARE claims.

This appeal is taken pursuant to 28 U.S.C. §1257(2).

Notice of Appeal

**BRESLIN, HERTEN &
LePORE, P.C.
Attorneys for Appellant-
Petitioner**

**By: Louis L. D'Arminio
LOUIS L. D'ARMINIO**

**14 Washington Place
Hackensack, New Jersey 07601
(201) 343-5678**

**NEW JERSEY SUPREME COURT DISMISSAL OF APPEAL
AND DENIAL OF CERTIFICATION**

**SUPREME COURT OF NEW JERSEY
C-70 SEPTEMBER TERM 1983**

21,488

BERGEN PINES COUNTY HOSPITAL,

Petitioner-Petitioner,

v.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES, et al,

Respondents-Respondents.

To the Appellate Division, Superior Court:

A petition for certification of the judgment in A-1005-80T4 having been submitted to this Court, and the Court having considered the same;

It is ORDERED that the petition for certification is denied; and it is further

ORDERED that the appeal in the within matter is dismissed pursuant to R. 2:12-9.

WITNESS, the Honorable Robert N. Wilentz, Chief Justice, at Trenton, this 24th day of October, 1983.

Dismissal of Appeal and Denial of Certification

Stephen W. Townsend
Clerk

A TRUE COPY
Stephen W. Townsend
Clerk

**OPINION OF THE SUPERIOR COURT, APPELLATE
DIVISION FILED MAY 27, 1983**

**SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
A-1005-80 T1**

BERGEN PINES COUNTY HOSPITAL,

Petitioner-Appellant,

v.

**NEW JERSEY DEPARTMENT OF HUMAN SERVICES; ANN
KLEIN, COMMISSIONER; NEW JERSEY DIVISION OF
MEDICAL ASSISTANCE AND HEALTH SERVICES;
THOMAS M. RUSSO, DIRECTOR; NEW JERSEY DIVISION
OF HEALTH ECONOMICS; JAMES HUB, DIRECTOR,**

Respondents-Respondents.

Argued March 8, 1983 — Decided May 27, 1983

Before Judges Michels, Pressler and Trautwein.

On appeal from the Department of Health.

Louis L. D'Arminio argued the cause for appellant
(Breslin, Herten & LePore, attorneys; Mr.
D'Arminio, of counsel and on the brief).

Ivan J. Punchatz, Deputy Attorney General,
argued the cause for respondents (Irwin I.
Kimmelman, Attorney General, attorney; James
J. Ciancia, Assistant Attorney General, of counsel;
Mr. Punchatz, on the brief).

*Opinion***PER CURIAM.**

Petitioner Bergen Pines County Hospital (BPCH) appeals from the Medicaid reimbursement rates established for its long-term care facility by the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), for several rate periods between July 1, 1976 and June 30, 1981. Pursuant to 42 U.S.C. §§1396 *et seq.*, DMAHS is authorized to administer New Jersey's Medicaid program. *N.J.S.A.* 30:4D-5. DMAHS's State Plan for Medicaid reimbursement must be approved by the Secretary of Health and Human Services. 42 U.S.C. §1396a(b).

In 1972, Congress amended Title XIX of the Social Security Act to require each State Plan to provide for payment of skilled nursing and intermediate care facility services "on a reasonable cost related basis." *P.L.* 92-603, title II, §249(a) (codified at 42 U.S.C. §1396a(13)(E)). This statute became effective on July 1, 1976. From July 1, 1976 until December 31, 1977, DMAHS reimbursed long-term care facilities under what the parties have designated the "pre-CARE" reimbursement system. Under this system, payment for administrative and general expenses, medical supplies, room and board, recreational therapy and nursing salaries was made according to each facility's reported costs, but not to exceed the average reported costs of all nursing homes of similar size and location plus ten percent (or plus one standard deviation in the case of nursing salaries). Other expense items, including drugs, oxygen and the services of a consultant pharmacist, medical director, and social services staff, were reimbursed at a fixed rate per patient per day. In calculating the average reported costs for each category of nursing home, DMAHS excluded the costs reported by county and State long-term care facilities, on the grounds that these facilities' reported costs were excessively high

Opinion

and often were improperly allocated between long-term care and other costs of operation. The pre-CARE reimbursement system was never approved by the Secretary of Health and Human Services.

BPCH was informed of its final per diem reimbursement rates under the pre-CARE system on July 29, 1976. These rates represented the maximum amounts permissible under the system for a nursing home of BPCH's size and location; BPCH's reported costs were substantially higher in each expense category. BPCH did not appeal the setting of these rates; however, on December 8, 1977, it requested a hearing before DMAHS on the question whether these rates represented an economic hardship to BPCH. DMAHS responded on January 4, 1978 that BPCH was receiving the maximum reimbursement permitted under the existing system, and therefore was not entitled to relief. BPCH apparently sought no further review of this decision.

Effective January 1, 1978, DMAHS and the Department of Health completely revised New Jersey's Medicaid reimbursement system for long-term care facilities. The new system, called the "Cost Accounting and Rate Evaluation" (CARE) guidelines, was intended to comply more strictly with the requirement of a "reasonable cost related" methodology embodied in 42 U.S.C. §1396a(13)(E). Under the CARE guidelines, *N.J.A.C. 10:63-3 et seq.*, a long-term care facility is reimbursed on a per diem basis for each of six "rate components": Raw food costs, general service expenses, property operation costs, amortization of special expenditures, patient care expenses, and property-capital costs (including return on investment). For each component, the facility receives the lesser of its average historical daily costs (the "historical rate") and the median reasonable expenses of all nursing homes adjusted for regional variations in salaries, plus

Opinion

a certain percentage to account for individual variation among facilities (the "screened rate"). *N.J.A.C.* 10:63-3.2(a). The calculation of the "screened rate" for all but amortized special expenditures does not account for the reported expenses of State and county facilities for the same reasons that these expenses were not included under the pre-CARE system. Facilities that believe the guidelines are inequitable as applied to them as the result of their unique circumstances can appeal within 30 days to the Department of Health. *N.J.A.C.* 10:63-3.20. The appeal (Level I) is heard by analysts from the Department of Health, whose recommendations are reviewed by the Director of DMAHS. A second appeal (Level II) may be taken from the Director's determination to a panel of designated representatives of the Department of Health and the Department of Human Services. *N.J.A.C.* 10:63-3.20(a)2. The CARE guidelines were approved by the Secretary of Health and Human Services on December 20, 1977.

BPCH brought a Level I appeal on May 30, 1978 from the reimbursement rates established by DMAHS for the rate period January 1, 1978 through June 30, 1978. While this appeal was pending, BPCH filed Level I appeals for the rate periods July 1, 1978 through June 30, 1979, July 1, 1979 through June 30, 1980, and July 1, 1980 through June 30, 1981. Each Level I appeal was denied. The denial of the first appeal was challenged at a Level II hearing. On January 29, 1980, the Department of Health issued its findings, which denied all of BPCH's requests for an increase in rates save a small increase for utility costs. As to the exclusion of governmental facilities from the calculation of the "screened" rate, the Department said:

Bergen Pines objects to these facilities being excluded from all screening statistical data. The

Opinion

county facilities are not excluded from all the screens, but, in the screens that do preclude the county facilities, this omission is performed in accordance with the regulations for all county facilities, not uniquely to Bergen Pines. The reason for this exclusion is the unreliability of the cost allocations used generally by this group. The conclusion on the unreliability was derived from the experience of Medicaid's Bureau of Audits in auditing previous years' cost filings. The County facilities will remain excluded in accordance with the regulations.

BPCH responded to the Department's decision with a lengthy rebuttal. On October 7, 1980, the Department responded to BPCH's exceptions and reaffirmed its earlier decision. BPCH filed a notice of appeal with this court on November 17, 1980.

As an initial matter, we hold that petitioner's appeal from the pre-CARE rates of July 1976 through December 1977 is long out of time and will not now be considered. The administrative action appealed from is DMAHS's setting of the final pre-CARE reimbursement rates, which took place on July 29, 1976. The latest arguable date would have been January 4, 1978, when the agency refused to increase those rates. This was more than two and a half years before the notice of appeal was filed. Because no administrative appeal process existed during the pre-CARE period, petitioner should have appealed directly to this court within 45 days. R. 2:4-1(b). See *Alberti v. Civil Service Com.*, 41 N.J. 147, 154 (1963). It did not do so. Accordingly, petitioner's appeal from the rate periods preceding January 1, 1978 is out of time and therefore is dismissed.

Opinion

We turn then to petitioner's challenge to the rates established under the CARE guidelines. Petitioner's principal contention is that the CARE system neither represents a "reasonable cost related" method of reimbursement, as required by 42 U.S.C. §1396a(13)(E) (amended by P.L. 97-35, Title XXI, §§2171, 2173, effective August 31, 1981) and by petitioner's annual Medicaid contracts with DMAHS, nor provides reimbursement of "the actual allowable costs of a facility that is economically and efficiently operated," as required by 42 C.F.R. §447.302. Petitioner's position is that the CARE system does not adequately account for the inherently higher cost of operating a State or county nursing home, and therefore results in an unreasonably low reimbursement rate when applied to such a nursing home. According to petitioner, costs are higher in a governmental facility because of the higher concentration of severely handicapped patients, the greater salaries and benefits, and the greater administrative costs in such facilities. Petitioner also contends that the CARE system should account for the greater costs inherent in operating a hospital-based nursing home. In support of its contentions petitioner has presented a substantial number of documents and affidavits and has presented its case at oral argument. This record, however, does not provide an adequate basis upon which to resolve the difficult and complex issues raised in this appeal. Petitioner should be given an opportunity to present, and respondents to rebut, these proofs in a full contested hearing.

For this reason, we remand those portions of this appeal that relate to the CARE system to the Department of Health for the taking of additional evidence and the making of findings of fact and conclusions of law thereon. R. 2:5-5(b). In part, the Department of Health should determine the actual operating expenses of BPCH, whether these expenses are attributable to factors unique to government facilities, and whether BPCH

Opinion

operated economically and efficiently during the rate periods at issue. The Department should further make specific findings and conclusions as to whether DMAHS was justified in excluding the reported expenses of State and county nursing homes from the CARE guidelines and whether the CARE system represented a "reasonable cost related" method of reimbursement. Petitioner should be afforded an opportunity at this hearing to present evidence on the other assignments of error raised in Counts II and III of its notice of appeal. The hearing shall be conducted and completed as soon as is practical and the Department shall file its decision with the clerk of this Court on or before September 30, 1983. All parties shall serve and file supplemental briefs on or before October 31, 1983. If further oral argument is requested counsel shall advise the clerk of this Court in writing on or before October 31, 1983. The Clerk is directed to schedule the appeal for argument or submission as soon thereafter as the calendar will permit. We retain jurisdiction.

I hereby certify that the foregoing is a true copy of the original on file in my office.

s/ Elizabeth McLaughlin
Clerk

**STATE OF NEW JERSEY MEDICAID REIMBURSEMENT
SYSTEM (LONG TERM CARE PROGRAM) (PRE-CARE
SYSTEM)**

**STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH
SERVICES
PROGRAM INTEGRITY ADMINISTRATION**

**Explanation of New Jersey Medicaid Reimbursement System
Implemented for Reimbursement to Long Term Care Providers
Effective July 1, 1976**

The method of calculating the New Jersey Medicaid (Medicaid) per diem reimbursement rates (rates) for participating Long Term Care Facilities (LTCF) has been revised. These revisions were prompted by the pending Federal legislation (92-603) which requires reimbursement on a "reasonable cost-related basis.

This explanation is intended to provide the following information:

I. The differences between last years 1975 Cost Study and the 1976 Cost Study and Coding Sheets.

II. Changes in the rate formula.

III. An explanation of our current methodology and output format.

I. Differences between 1975 and 1976 Cost Studies

The format of the 1976 Cost Study was changed as follows:

A. Schedule B — Statement of Operations

Medicaid Reimbursement System

1. Dietary and Food (line 2,A) were combined as one line item

2. Housekeeping and Laundry (line 2,B) were combined as one line item.

3. Separate lines were provided for:

- a. Non-Legend Drugs (3,E)
- b. Medical Director (3,G)
- c. Oxygen (3,M)
- d. Social Service (3,N)

4. Plant operations was consolidated into:

- a. Maintenance and Repairs (4,A)
- b. Utilities (4,B)

5. Equipment Rental was moved to Other Administrative (pg. 11, line E,10)

B. Exhibit I — Administrative and General Expenses

1. Interest (other than real property) was segregated from Other Administrative expenses and included as Line D.

2. A separate line (E,1) was provided for the Amortization of Start-up Costs.

3. Postage was included with Office Supplies on Line E,3.

4. Equipment rental was moved from Plant Operations to Other Administrative (E,10). This move was

Medicaid Reimbursement System

generated by the de— to compare equipment rental cost with depreciation on movable equipment, which was already reported as Other Administrative Cost.

C. Exhibit II — Adjustments to Operating Expenses

This Exhibit was expanded to provide at least one line to adjust every line on Exhibit I and Schedule B. Additionally, to eliminate disparity and confusion, column (4) now includes the exact line number on Schedule B on which the amounts adjusted should be reported.

D. Summary

We recognized that even with the aforementioned changes, these forms are not easily adaptable to automated data processing. The decision was made not to drastically alter the Cost Study format but to add Computer Coding Sheets with Instructions. It was felt that this action, although apparently double work, would minimize confusion and error.

II. Changes In Rate Formula

In addition to the adoption of the "reasonable-cost related" reimbursement methodology which will be explained in III, the following other changes were made:

A. The limitations on owners', officers' and/or administrators' salaries heretofor subject to the Instructions (MCNH-1A, Rev. 12/75), page (D), line 4,A and page (K), have been removed. Any Exhibit II adjustments reported by facilities pursuant to these instructions were reversed by our Auditors during the desk-audit processing.

Medicaid Reimbursement System

It was our opinion that since we intend to control total administrative costs as one "cost center" (explained in III), and since administrative costs can generally be considered overhead, it is no longer necessary to specifically limit these salaries. The only limit on these salaries would be based on allocations for facilities which include other than Medicaid participating units.

B. Our instructions page (D), line 4,d have stated that "interest other than that related to real property", "paid to a related lender", is "*not-allowable* and should be adjusted on Exhibit II". This instruction is generally consistent with Medicare regulations.

We have made exceptions to this policy when facilities borrow from related lenders for sound business purposes. In such exceptions the following criteria must be met:

1. A formal loan agreement exists between the facility and the related lender. This agreement must stipulate a definite period of repayment and the interest rate.

2. The money was required for sound business purposes directly related to the operation of the nursing facility (i.e., reasonable and necessary).

3. Evidence exists that the money was actually received and recorded by the facility and used only for the purposes specifically explained in criterion #2.

4. The rate of interest must be no greater than the going market at the time of the loan (i.e. what a bank would charge).

Medicaid Reimbursement System

5. Evidence must exist that the facility and the related lender actually perform pursuant to the agreement pursuant to criterion #1.

C. The Health Care component of total cost was expanded to include:

1. A provision for non-legend drugs as defined in Circular letter #71, dated March 15, 1976. Since generally there *exists no sufficient historical cost data from which to determine reimbursement for this item*, this Division has estimated the cost for providing this service. The estimated cost of 15 cents per Medicaid patient day is used for determining the reimbursement of all facilities effective July 1, 1976.

It should be noted that this fixed rate is also subject to our projections for economic inflation. It is conceivable *that if accurate historical cost data is available in subsequent years, reimbursement of actual reasonable cost may be substituted for fixed rates.*

2. A 5 cents per Medicaid patient day "add-on" is being provided for the cost of providing Consultant Pharmacist services. Effective July 1, 1976, the method of reimbursing these services as explained in Circular Letters #67 and #72 is being discontinued. Participating facilities are again responsible for contracting for these services in accordance with the procedures in effect prior to March 1, 1976. Any questions regarding reimbursement for consultant Pharmacist services in LTCF's should be referred to:

Medicaid Reimbursement System

Mr. Sanford Luger, Acting Chief
Pharmaceutical Services
Division of Medical Assistance
and Health Services
(609-292-3756)

3. The amount of 22 cents per Medicaid patient day is being provided for the services of a *Medical Director* as explained in *Circular Letter #78*. This provision, like that for non-legend drugs, *was estimated by the Division*. It is also conceivable that in subsequent years, the cost of Medical Directors will be reimbursed based on reasonable historical cost at that time.

All SNF's and combination SNF's/ICF's are required to have a Medical Director. This Division is encouraging "ICF only" facilities, which apparently are not required to provide this service to do so for the general well-being of the patients. Consistent with our wish to encourage these services, we are including the 22 cents Medicaid patient day provision in the reimbursement for *all* participating facilities.

"ICF only" facilities must notify this Division in writing if they intend to voluntarily provide this service.

The amount reimbursed to SNF's and combination SNF's/ICF's which must provide this service, and to "ICF's only" which voluntarily choose to provide this service, will be subject to retroactive recovery, in whole or in part, if the services are not implemented on a timely basis.

Medicaid Reimbursement System

4. A 2 cents per Medicaid patient day "fixed rate" is being provided *for oxygen expense*, in accordance with Circular Letter #78. This provision like those for non-legend drugs and Medical Directors, *was determined* by the Division. It is also conceivable that in subsequent years, the cost of providing oxygen will be reimbursed based on reasonable historical cost at that time.

5. A 20 cent per Medicaid patient day "fixed rate" is being provided for Social Services in accordance with Circular Letters #78 and #62. It is also conceivable that, in subsequent years, these services will be reimbursed based on reasonable historical cost at that time.

The reimbursement will also be subject to retroactive recovery in whole or in part if the required services are not implemented on a timely basis.

D. The current one (1) per cent allowance (in lieu of depreciation) for *voluntary and governmental facilities* was reduced from two (2) percent last year. This is the last year this allowance will be provided. Affected providers that have not already done so are urged to establish historical cost records for "real property" costs.

III. Explanation of Current Methodology and Output Format.

This part will follow the format of the "Nursing Facility Cost Study Evaluation for Rate Determination for 1976" (printout). As the printout format is discussed, the methodology will be explained.

A. Page Headings — Statistical Data

Medicaid Reimbursement System

The printout for each facility consists of four pages, numbered consecutively. The headings at the top of each page are identical.

1. The date at the top left corner signifies the date the "printout" was processed by the computer.

2. The page number at the top, right corner is insignificant. It represents the continuous numbering of pages processed by the computer.

3. The provider number represents the five digit Medicaid provider number assigned to the facility. For SNF's and combination SNF's/ICF's, the number used is the SNF number. For ICF's only, the number used is the ICF (A) number.

4. The page number to the right of the provider number represents the consecutively numbered page of the four page printout.

5. The number under the heading of beds represents the bed capacity of the facility.

This number is significant because, as explained in a later part of this guide, *the costs for each facility are compared to other facilities of the same relative bed capacity.*

The bed capacities were broken-down into three groups:

- a. 0-60 beds
- b. 61-180 beds
- c. 181 + beds

Medicaid Reimbursement System

6. The number under the heading of "days" represents the number of days in the period for which costs were reported by the facility.

This number is significant because items of expense (i.e. depreciation, insurance, taxes-), which usually are computed or paid on a yearly basis, should be prorated accordingly.

7. The name of the facility is to the right of the heading labelled "days".

8. The alpha character U or R under the heading of U/R represents the geographic location classification assigned to the facility. The classification is determined by the County in which the facility is located.

Page (L) of the cost study instructions (MCNH-1a, rev. 12/75) classifies Counties as either urban or rural. The first two digits of the Medicaid provider number represents the County, since the numbers were assigned consecutively to the Counties in alphabetical order.

For other purposes of "real property" reimbursement, Atlantic City is considered as urban, whereas Atlantic County is considered rural. For purposes of comparing the costs, other than "real property", Atlantic City is also considered rural.

The method by which the U/R classification is used in conjunction with the capacity will be further explained.

9. The numbers under the heading "Dates, From-To" represent the period for which costs were reported on the cost study (MCNH I, rev. 12/75).

Medicaid Reimbursement System

Example: If costs were reported for the period January, 1975 to December 31, 1975 the entry would appear as 0175 - 1275. These dates are significant not only as they relate to the number of days used for the proration of applicable costs but also as they relate to the projection for economic inflation. The projection will be explained further.

10. The number under the heading "County" represents the first two digits of the provider number. The application of these numbers has previously been explained herein.

11. The number under the heading of "Skilled Days" represents the *total* (not just Medicaid) patient days of SNF care rendered by the facility which was reported for the period of cost study.

12. The number under the heading of "ICF A Days" represents the *total* patient days of ICF (A) care, rendered by the facility, which was reported for the period of the cost study.

13. The number under the heading of "ICF B Days" represents the total patient days of ICF (B) care, rendered by the facility, which was reported for the period of the Cost Study.

14. The number under the heading of "Patient Days" represents the *total* patient days rendered by the facility for all levels of care, to all patients, for the period of the cost study.

This number should be the numerical total of the three previous, lefthand columns.

This number is significant, in that, once adjusted for weighting by level of care, it was divided into the adjusted total allowable costs to determine the per diem costs.

Medicaid Reimbursement System

This application will be discussed further, herein.

15. The number under the heading of "Medicaid Days" represents the total number of patients days of care rendered to Medicaid patients, as reported for the period of the cost study. This number is significant, in that, it is used to statistically weight the cost data for the generation of comparative tables, which will be further explained.

Cost data is weighted by Medicaid days for the purpose of developing averages which lend due consideration to the number of Medicaid patients receiving care in relation to the cost of providing such care.

16. The number under the heading of "Medicaid Patients" represents the number of Medicaid patients reported to be in the facility on December 31, 1975. This number is only informational and has no significance in the calculations.

It should be noted that for those facilities which experienced less than eighty (80) percent occupancy for the period reported, the patient days reported were adjusted upward to eighty (80) percent of maximum patient days. In these instances, the variable costs were also adjusted accordingly. The detail of these adjustments can be found on Schedule I, form MCNH-65 (Rev. 3/76).

17. The number under the heading "PFF" represents the statistical weighting factor (by level of care) which is applied to the adjusted total costs after the said costs have been projected. The projected, weighted, adjusted total costs are divided by the total patient days to compute the per diem costs.

Medicaid Reimbursement System

18. The number under the heading "Admin Factor" represents the decimal equivalent of the percentage that total administrative costs relates to total other allowable costs on an average. This number is of no significance in the subsequent computations.

19. The number under the heading "Proj" represents the projection for economic inflation by which the adjusted total costs is multiplied to determine projective reimbursement rates for the State fiscal year ending June 30, 1977.

The actual calculation of the projection is found on the "LTCF Per Diem Computation Sheet" (MCNH-65, rev. 3/76).

B. Column Headings — Cost Analysis

The column headings are also printed on each page to facilitate reference.

1. The expense classifications listed under the heading "Expense Item" represents the classifications used within the Cost Study. The classifications are listed in the same order as they appear on Exhibit I and Schedule B of the Cost Study.

The Cost Study accumulates expenses into six (6) major areas:

- a. Administrative and General
- b. Room and Board
- c. Health Care
- d. Plant Operations
- e. Property Expenses
- f. Miscellaneous Expenses

Medicaid Reimbursement System

For purposes of current reimbursement calculation, expenses have been accumulated into thirteen (13) areas or "cost centers":

- a. Administrative and General
- b. Room and Board
- c. Nursing Salaries
- d. Medical Supplies
- e. Non-legend Drugs
- f. Medical Director
- g. Recreational Therapy
- h. Oxygen
- i. Social Services
- j. Other Health Care
- k. Plant Operations
- l. Property Expenses
- m. Other Miscellaneous Expenses

2. The numbers listed under the column headings of "Salaries" and "Non-Salary" represent the amounts reported for each line item from Schedule B, Column one (1) and two (2) of the cost study.

3. The numbers listed under the heading of "Fac Adjust" represent the amounts by which the facility adjusted their own expenses, pursuant to our instructions. These amounts should agree with Exhibit II as transferred to Schedule B, Column three (3) of the cost study.

4. The numbers listed under the heading "D.A. Adjust" represent the amounts by which the expenses reported were adjusted during the desk-audit process. An explanation of these adjustments is located on Schedules I & III of form MCNH-65 (Rev. 3/76).

Medicaid Reimbursement System

5. The numbers listed under the heading "Adjust Costs" represent for each expense classification the sum of the amounts listed under "Salaries" and "Non Salary", plus or minus the amounts listed under "Fac Adjust" and "D.A. Adjust".

The total under this column, classified as "Total Expenses", should be the same as line 5, MCNH-65 (Rev. 3/76). "Adjusted operating expenses".

6. The amounts listed under the heading "This Facility", "% — "PD" represent the relationship of each line item of the facility's adjusted cost to the adjusted "Sub-Total Expenses" either as a percentage or as a proportionate part of the per diem cost.

The percentage amounts are for informational uses only and may be used as an effective management tool by both this Division and the particular facility.

The per-diem amounts are significant since they are used in the calculations.

It should be noted that the per diem amounts in this column and the column to the right have been weighted ("PFF") by level of care and therefore reflect level IV (A) ICF which is used as the base level for the calculations.

To facilitate data processing, instead of weighting the patient days by level of care, as detailed in the manual computation sheet MCNH-65 (Rev 3/76), line 9, the costs have been weighted. The costs are weighted by the reciprocal (PFF) of the weighting factor used manually to adjust the days.

Medicaid Reimbursement System

7. The per diem amounts listed under the column heading of "Bed Cap, Table, PD" *reflect the weighted average per diems for each expense item for all facilities of the same relative bed capacity.* The breakdown by bed capacity is explained in part II, C, 5 of this explanation.

The weighting of costs for the development of this table is explained in part III, A, 15 of this explanation.

8. The per diem amounts listed under the column heading of "Locat, Table, PD" *reflect the weighted average per diem for each expense item for all facilities of the same relative location (U/R).* The breakdown by location is explained in part III, A, 8 of this explanation.

9. The per diem amounts listed under the column heading of "Comp, Table, PD" *reflect the composite weighted average per diems for all facilities of the same relative bed capacity and location.* These per diem amounts are not the numeric sum of the previous two columns. These per diem amounts are significant in that for certain "cost centers" they are used in the determination of the "rate".

10. The per diem amounts listed under the column heading of "Fixed Rate, PD" *reflect the Division's estimate of the reasonable reimbursement for certain "cost centers".* The "cost centers" affected by this method are discussed in part II, C, Lines 1, 2, 3 and 4. Additionally, the "fixed rate" reimbursement method for nursing salaries will be discussed in detail, later in this explanation.

11. The per diem amounts listed under the column heading "Rate, PD" represent the "rates" for each "cost center".

Medicaid Reimbursement System

C. "Rate" Calculations by "Cost Center"

The "rate" for each "cost center" is determined by means of one of the following methods.

1. Weighted Average Method

a. Where the per diem for "This Facility" falls within the weighted average per diem ("Comp Table") plus ten (10) percent, the "Rate" is equal to "This Facility's" per diem.

b. Where the per diem for "This Facility" is less than the weighted average per diem (Comp Table) the "Rate" is equal to *"This Facility's" per diem plus five (5) per cent of the weighted average per diem, but not to exceed the weighted average per diem.*

c. Where the per diem for "This Facility" is greater than the weighted average per diem plus ten (10) per cent of the weighted average per diem, the "Rate" is equal to the weighted average per diem *plus 10% of the weighted average per diem.*

Examples:

THIS FACILITY PD	COMP TABLE PD	RATE PD
a. \$6.50	\$6.00	\$6.50
b. \$5.00	\$6.00	\$5.30
c. \$7.00	\$6.00	\$6.60

Medicaid Reimbursement System

It should be noted that an *incentive* for apparent operating efficiency is given for those "Rates" calculated pursuant to method (1, b). A report will be generated listing all facilities for which such incentives were given by "expense item". This report will be forwarded to the New Jersey Department of Health for use in their periodic inspections to determine conformance with established standards. If it is subsequently determined that incentives were given in areas that were found to be sub-standard, and these sub-standard areas were not corrected on a timely basis, any incentives given may be subject to retroactive recovery in part or in whole. Any such retroactive recoveries would be in addition to the usual actions taken by the Department of Health and this Division in areas found to be sub-standard.

The "cost centers" affected by this method are:

- (1) Administrative and General
- (2) Room and Board
- (3) Recreational Therapy

2. Standard Deviation Method

The only "cost center" affected by this method is that for nursing salaries. A Nursing Component Model was calculated and is reflected under the column heading of "Fixed Rate, PD". The model is different for each composite grouping (ie. U/R, bed capacity). The models were calculated as follows:

A. Parameters

1. Number hours of nursing care required for each type employee (RN, LPN, Aide), as prescribed in the

Medicaid Reimbursement System

Manual of Standards for Intermediate Care Facilities by the Health Department.

For level A, total hours of nursing care
= -2.5 hours consisting of

.31 hours of RN care

.11 hours of LPN care

2.08 hours of Aide care

plus the director of nursing who average
.11 hours per bed per day in facilities whose size is over 60 beds.

2. These parameters were used for facilities with more than 57 beds. Where there were fewer than 57 beds, the rate was directly determined by bed size. Variables by type of employee in the smaller facilities were:

RN = .32 hours

LPN = $(168 \div \text{bed size} - 7) \times .32$

Aide = $2.5 - (168 \div \text{bed size} + 7)$

B. Application

1. A sample of nursing facilities were used to determine, as at December 1975, the average wage per hour of the nursing facility employees. These homes presented nursing salary data showing type of personnel (RN, LPN, Aide), number of hours per week that each worked, and the hourly wage at each level.

Medicaid Reimbursement System

From this information, an *average rate per hour was determined for RN's LPN's and Aides*. Separate rates were computed for urban and rural homes.

Subsequently the rates were multiplied by the number of hours of care required at the A level, and finally increased by to account for employer costs associated with employee wages such as vacations, sick time and holidays.

A standard deviation was calculated on the distribution of results.

2. In order to verify sample results, actual cost study data were analyzed. Total salary costs from 132 facilities for RN's, LPN's and Aides were divided by total patient days to determine daily costs. Separate results were computed for proprietary, voluntary and governmental homes as well as urban and rural facilities, and a comparison to sample data was made.

3. At that time all computed sample rates were reduced by .0335 (3.35%), (multiplied by .9665) to make them comparable to the time period for which the cost studies were submitted.

These rates became the average health care components with a standard deviation of \$1.18, and constituted the model against which the Adjusted Per Diem was compared.

4. Then assuming 1.25 hours of care for level B and 2.75 hours for skilled, these were expressed in terms of A days:

Medicaid Reimbursement System

$$\text{Skilled} = 2.5 \times 1.1 = 2.75$$

$$\text{Level B} = 2.5 \times 0.5 = 1.25$$

$$\text{Total adjusted days} = (1.1) \text{ skilled days} \\ + \text{A days} + (.5) \text{ B days}$$

$$\text{Adjusted Per Diem} = \frac{\text{Total Nursing Costs}}{\text{Adjusted Days}}$$

The "adjusted total cost" and the "adjusted per diem" for "This Facility" are reflected to the right of "Nursing Rate". These amounts are used only for the calculation of the nursing salaries "rate" and are not added into the columns in which they appear.

5. The rate is calculated by multiplying the "adjusted total cost" (ATC) by the "PFF" then dividing by the "Patient Days" (D).

(a) Where the adjusted per diem for "This Facility" falls within the "model" plus the standard deviation, the "ATC" is This Facility's Total Costs.

(b) Where the adjusted per diem for "This Facility", falls between the "model" and the "model" minus one half (1/2) the standard deviation, the "ATC" is equal to the "model" multiplied by the adjusted days.

(c) Where the adjusted per diem falls below the "model" minus one half (1/2) the standard deviation, the "ATC" is equal to the Adjusted Per Diem plus one half (1/2) of the standard deviation multiplied by the adjusted days.

Medicaid Reimbursement System

(d) Where the adjusted per diem for "This Facility" is greater than the "model" plus the standard deviation, the "ATC" is equal to the model plus the standard deviation multiplied by the adjusted days.

3. The Fixed Rate Method

As previously discussed in Part II, C, Lines 1, 2, 3 and 4 and part III, B, 10 of this explanation, certain "cost centers" are reimbursed at a "fixed rate".

4. The Weighted Average Method minus incentives

The weighted average method, as previously discussed in Part III, c, 1; without added incentives pursuant to III, C, 1, b; is applied to the Medical Supplies "cost center", except where the per diem for "This Facility" is less than the weighted average per diem. The "rate" for those instances is equal to the "This Facility's" per diem.

5. Actual Cost Method

The actual costs are allowed for those "cost centers" where comparisons between facilities are not considered appropriate. The "cost centers" affected by this method are:

- a. Other Health Care
- b. Plant Operations
- c. Property Expenses
- d. Other Miscellaneous Expense

For these "cost centers" the rate is equal to the per diem amount under "This Facility".

Medicaid Reimbursement System

It should be noted that the reimbursement formula for property expenses has remained unchanged. It is anticipated that the formula for this "cost center" will be revised for "rates" effective July 1, 1977.

D. "Rate" Calculation

1. The "rates" for each "cost center" listed under the column headed "Rate, PD" are totalled.

2. This total is reflected in this column to the right of "Sub-Total Expenses".

3. Any one (1) per cent allowance for qualifying facilities (II, D) is added and the total is reflected in this column to the right of "Total Expenses".

4. The next line ("Projected Expenses") again reflects the projection ("PROJ") under the column headed "Non Salary".

5. The total adjusted cost is projected by this "PROJ" and reflected under the column "Adjust Cost".

6. "The facility's adjusted weighted per diem is projected and reflected under the column "This Facility, PD".

7. The "Rate" for this facility is projected and reflected under the column headed "Rate".

8. The next line ("Expenses *PF .F.") reflects the projected total adjusted costs multiplied by the weighting factor ("PFF"). This number when divided by the total actual patient

Medicaid Reimbursement System

days equals the projected per diem reflected under "This Facility, PD" to the right of "Projected Expenses".

9. The next three lines under "This Facility, PD" reflect the per diem costs for the facility, calculated as follows:

a. The per diem cost of the facility for ICF (A) is equal to "projected per diem" (III, D, 8).

b. The per diem cost of the facility for ICF (B) is equal to ninety (90) percent of the per diem cost for ICF (A).

c. The per diem cost of the facility for SNF is equal to one hundred and five (105) per cent of the per diem cost for ICF (A).

10. The next three lines under "Rate PD" reflect the total "rates for the facility, calculated as follows:

a. The rate for ICF (A) is equal to the projected "rate" (III, D, 7).

b. The "rate" for ICF (B) is equal to ninety (90) per cent of the ICF (A) "rate".

c. The "rate" for SNF is equal to one hundred and five (105) per cent of the ICF (A) "rate".

11. The "rates" for each level of care are increased by a \$.05 per day provision for a pharmaceutical consultant as discussed in part II, C, 2.

Any questions should be referred to:

Medicaid Reimbursement System

Mr. William H. Metcalf, Deputy Director
(609-292-7112)

or

Mr. Donald J. Bucchi, Acting Deputy
Assistant
Director for Program Integrity
Administration
(609-292-6837)

Any questions regarding specific rates should be referred to the Bureau of Audits: (609-292-6836)

Due to the potential activity of the State Department of Health in rate setting for fiscal year 1978 and the requirements of Section 249-PL 92-603 that all payment methodologies be approved and validated by the Secretary of HEW, it is not possible to assure facilities that this format will be carried forward to future years in tact.

**LETTER OF GERALD REILLY RE: BERGEN PINES PER
DIEM REIMBURSEMENT RATE DATED JULY 29, 1976**

STATE OF NEW JERSEY

**DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH
SERVICES**

July 29, 1976

02810 BERGEN PINES CO HOSP
RIDGEWOOD ID
PARAMUS NJ

Re: Per Diem Reimbursement
Rates

Dear Administrator:

Fiscal year 1977 per diem reimbursement rates for Long Term Care Facilities have been established effective July 1, 1976. The rates have been established based on the information reported on the 1976 Cost Studies (MCNH-1, Rev. 12/75) which were processed through a computerized system for determining reimbursement on a "reasonable cost related" basis.

The final rates established for your facility, effective July 1, 1976, are:

Provider Number	Level Of Care	Per Diem Rate	Limited To
02810	SNF	33.22	—
02817	A	31.64	—
02818	B	28.48	—

Letter

* The final rates will be limited to the lowest semi-private room rates (4, 3 or 2 beds) as certified on the latest MCNH-30.

These rates are subject to a future on-site audit. The estimated cost of providing federally mandated services (ie. Medical Director and Social Services) have been included in the reimbursement effective July 1, 1976 on the assumption that facilities have or will immediately complement these services. If it is determined upon field audit that facilities have not implemented these services in a timely manner, amounts reimbursed for these services will be subject to retroactive recovery in whole or in part.

Questions regarding these rates should be referred to Mr. Nicholas Perroni, Chief Auditor, Bureau of Audits (609-292-6836).

Very truly yours,

s/ Gerald J. Reilly
Gerald J. Reilly, Director
Div. of Medical Assistance
and Health Services

GJR:B:p

Attachments

**LETTER OF EDWARD M. LEWIS TO DONALD J. BUCCHI
RE: SCHEDULING OF HEARING DATED DECEMBER 8,
1977**

**BERGEN PINES COUNTY HOSPITAL
East Ridgewood Avenue, Paramus, NJ 07652
201/261-9000**

December 8, 1977

Mr. Donald J. Bucchi
Acting Deputy Assistant Director
Office of Program Integrity Administration
Division of Medical Assistance and Health Services
P.O. Box 24625
Trenton, New Jersey 08605

Dear Mr. Bucchi:

Reference is made to your letter to Mr. McCarthy dated November 15, 1977 regarding the scheduling of our 1976 Audit. You indicated in your letter that the audit would be conducted some time between April, 1978 thru July, 1978 which is approximately 5 to 7 months in the future.

As you know, our per diem reimbursement rate for 1976 in our Skilled Nursing Facility is substantially under our actual cost for the same unit. Also, this facility is approximately 90% occupied by Medicaid patients for an estimated number of 160,000 Medicaid patient days at \$15.00 a day. The above information can only further establish the economic hardship placed in this institution by the current 1976 per diem reimbursement.

Accordingly, might I request a hearing with you or your superiors prior to your conducting of the 1976 Audit to establish a more equitable payment rate for the period in question.

Letter

We are looking forward to hearing from you regarding our Skilled Nursing Facility Audit. If you wish to contact me please do not hesitate to do so.

Very truly yours,

s/ Edward M. Lewis
Edward M. Lewis
Assistant Executive Director

EML:em

cc: J. Gillen
T. Casey
M. Elliott
C.R. Henning Associates

**LETTER OF DONALD J. BUCCHI TO EDWARD LEWIS RE:
AUDIT AND RATES DATED JANUARY 4, 1978**

January 4, 1978

292-0937

Mr. Edward M. Lewis
Assistant Executive Director
Bergen Pines County Hospital
East Ridgewood Avenue
Paramus, New Jersey 07652

Dear Mr. Lewis:

Reference is made to your letter dated December 8, 1977. It is true that we have scheduled your facility for audit, however, you should be advised that the purpose of this audit is not to establish per diem reimbursement rates. Audits are conducted by this Division to determine the accuracy of cost studies submitted by facilities and to determine the appropriateness of patient's available income and other items reported to the Bureau of Claims and Accounts.

With regard to the appropriateness of your per diem reimbursement rate, the information provided us by Mr. Henning has been reviewed by our Bureau of Audits. Your facility is receiving the maximum 110 percent of the composite in the Administrative and General and Room and Board cost centers. Your costs exceed this maximum by \$5.80 per day. Your nursing costs of \$17.58 per day exceed the nursing model by \$7.54 a day. It is true that your facility's costs far exceed your per diem, however, based upon the limitations of our payment system, there is no current basis for increasing your per diem reimbursement rate.

46a

Letter

Very truly yours,

Donald J. Bucchi
Acting Deputy Assistant Director
Office of Program Integrity
Administration
Division of Medical Assistance
& Health Service

DJB:m

cc: Mr. Thomas M. Russo
Mr. Nicholas J. Perroni

MAR 22 1984

No. 83-1409

~~ALFONSO L. STEVAS.~~

CLERK

In The
Supreme Court of the United States
October Term, 1983

BERGEN PINES COUNTY HOSPITAL,
Appellant,

vs.

NEW JERSEY DEPARTMENT OF HUMAN
SERVICES, ANN KLEIN, COMMISSIONER;
NEW JERSEY DIVISION OF MEDICAL
ASSISTANCE AND HEALTH SERVICES;
THOMAS M. RUSSO, DIRECTOR;
NEW JERSEY DIVISION OF HEALTH
ECONOMICS; JAMES HUB, DIRECTOR,
Appellees.

On Appeal from the Supreme Court of New Jersey

**MOTION OF APPELLEES TO DISMISS APPEAL
OR, IN THE ALTERNATIVE, TO AFFIRM JUDGMENT**

IRWIN I. KIMMELMAN
Attorney General of New Jersey
Attorney for Appellees
Richard J. Hughes Justice Complex
CN 112
Trenton, New Jersey 08625
(609) 292-8554

JAMES J. CIANCIA
Assistant Attorney General
Of Counsel
IVAN J. PUNCHATZ
Deputy Attorney General
On the Brief

QUESTIONS PRESENTED

1) Does the Court have jurisdiction over this case since it was dismissed by the State courts as untimely under the rules of practice governing the courts of the State of New Jersey?

2) Is a substantial federal question raised by the dismissal of the claims of appellant as untimely?

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No. 83-1409

In The
Supreme Court of the United States
October Term, 1983

BERGEN PINES COUNTY HOSPITAL,
Appellant,

vs.

NEW JERSEY DEPARTMENT OF HUMAN
SERVICES, ANN KLEIN, COMMISSIONER;
NEW JERSEY DIVISION OF MEDICAL
ASSISTANCE AND HEALTH SERVICES;
THOMAS M. RUSSO, DIRECTOR;
NEW JERSEY DIVISION OF HEALTH
ECONOMICS; JAMES HUB, DIRECTOR,
Appellees.

On Appeal from the Supreme Court of New Jersey

**MOTION OF APPELLEES TO DISMISS APPEAL
OR, IN THE ALTERNATIVE, TO AFFIRM JUDGMENT**

Pursuant to Rule 16, Paragraphs 1 (b) and 1 (c), of
the Revised Rules of this Court, appellees move that this
appeal be dismissed or, alternatively, that the judgment of
the Supreme Court of New Jersey be affirmed.

STATEMENT OF THE CASE

On November 17, 1980, appellant, a county owned and
operated nursing home, filed a notice of appeal with the
Appellate Division of the Superior Court of New Jersey,
wherein, among other things, appellant requested that
damages be awarded in the form of retroactive increases

in its Medicaid per diem rate of reimbursement. Appellant's claim was based on its allegation that the former reimbursement system, which had been discarded effective January 1, 1978, had not been in compliance with the former federal requirement that long-term care facilities (LTCFs), or nursing homes, be reimbursed on a "reasonable cost related basis" (42 U.S.C. §1396 a(a) (13) (E) (1972) amended by Pub.L. 96-499, §962, 94 Stat. 2599 (Eff. October 1, 1980)) for services rendered to Medicaid recipients.

Pursuant to N.J.S.A. 30:4D-1 *et seq.*, the State of New Jersey has participated in the Medical Assistance Program (Medicaid) established by Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.*, and jointly funded by the State and Federal governments. Although the program is primarily administered by the State, it is done so in accordance with Federal guidelines and requirements under Title XIX. *Harris v. McRae*, 448 U.S. 297, 301 (1980).

With regard to the payments for nursing homes, in 1972 Congress amended Title XIX of the Social Security Act to require that a State Plan for medical assistance provide as follows:

effective July 1, 1976, for payment of the skilled nursing and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary. [Pub.L. 92-603, Social Security Amendments of 1972, §249(a), 42 U.S.C. §1396a(a) (13) (E) (1972)].

Regulations promulgated by HHS postponed the effective date for implementation of the reasonable cost related methodologies to January 1, 1978. 45 C.F.R. §250.30(a) (3) (iv) (1976), 41 F.R. 27300 (July 1, 1976); but see, *Alabama Nursing Home Ass'n. v. Califano*, 433 F.Supp. 1325, 1330-1331 (M.D. Ala. 1977) (holding such regulation to be invalid insofar as it sets an effective date other than July 1, 1976).

In order to comply with this Federal requirement, the Division of Medical Assistance and Health Services (DMAHS) implemented a new method of calculating the per diem rates of reimbursement for nursing homes on July 1, 1976 (J.S. App. at 17a to 40a). Primarily, this new methodology, or pre-CARE system,* utilized the reported costs of the participating facilities to develop prospective rates of Medicaid reimbursement. For some cost areas, such as administrative or room and board, a statewide weighted average was used and an LTCF was eligible for reimbursement of costs in each category up to the appropriate average plus 10%. Nursing hours were reimbursed by utilizing a complicated standard deviation method while other costs centers, such as non-legend drugs, medical director and oxygen, were reimbursed at a flat fixed rate per day. Plant operations (maintenance and utilities), other health care and other miscellaneous expenses were reimbursed at a rate equal to the actual costs reported by the facility.

*This methodology has been referred to as the "pre-CARE system" in the decision of the Appellate Division and various documents filed with the courts since the successor system is known as the Cost Accounting and Rate Evaluation (CARE) system.

With regard to the governmental facilities, such as appellant, the cost methodology utilized was the same as that utilized for the proprietary and voluntary non-profit facilities. In establishing the cost ceilings for those centers which were subject to a weighted average, i.e., administrative and general, room and board, recreation costs and medical supplies, and nursing costs, the expenses reported by the governmental facilities were not utilized to establish the reimbursement ceilings. This exclusion was based upon conclusions drawn by the Bureau of Audits, DMAHS, regarding the lack of adequate documentation provided by these facilities to justify the expenses incurred. This problem was one of long-standing concern and to a great degree resolved around the inability of these governmental facilities to properly allocate the costs necessary and attributable to the LTCF operation apart from other costs of operation. Additionally, the figures reported by the governmental facilities on their 1975 cost studies had demonstrated that their reported costs were exclusively high and out of sync with the overall industry.

On July 29, 1976 appellant was notified of its final rates to be utilized for payment purposes beginning July 1, 1976 (J.S. App. at 41a to 42a). The finality of these rates were reinforced by the inclusion of the following paragraph describing the audit process:

These rates are subject to a future on-site audit. The estimated cost of providing federally mandated services (i.e. Medical Director and Social Services) have been included in the reimbursement effective July 1, 1976 on the assumption that facilities have or will immediately implement these services. If it is determined upon field audit that facilities have not implemented these services in a timely manner, amounts re-

imbursed for these services will be subject to retro-active recovery in whole or in part. [J.S. App. at 42a].

Appellant did not appeal this rate determination to the courts after receiving this notice. Appellant eventually did contact DMAHS with regard to a pending audit of Medicaid expenditures to the facility (J.S. App. at 43a to 44a). However, by way of letter dated January 4, 1978, appellant was informed that (1) the purpose of the audit was not to establish per diem reimbursement rates, and (2) that the per diem reimbursement rates had been reviewed and that there was no basis for increasing the rate (J.S. App. at 45a to 46a).

The letter further noted that appellant received the maximum 110% of the weighted average for the administrative and general and room and board cost centers but that nevertheless appellant's costs exceeded this maximum by \$5.80 per diem (*Ibid.*). Similarly, although appellant received the maximum allowable amount under the nursing hours model, its costs exceeded the model by \$7.59 a day (*Ibid.*). Thus, the State concluded that the reimbursement methodology did not allow for any further increases in appellant's per diem (*Ibid.*). Appellant did not file an appeal from this letter reiterating the final rates established on July 29, 1976.

On November 17, 1980, in conjunction with the present appeal, appellant for the first time appealed its per diem rates of reimbursement utilized under the pre-CARE system, notwithstanding the fact that use of the methodology and the rates established under it had ceased as of December 31, 1977 with the advent of a new system, or the fact

that the federal statute had been amended to remove the "reasonable cost related basis" requirement. Pub.L. 96-499, §962, 94 Stat. 2599 (Eff. October 1, 1980).

In its review of the case, the Appellate Division of the Superior Court dismissed the appeal of the pre-CARE rates as untimely in the following manner:

*As an initial matter, we hold that petitioner's appeal from the pre-CARE rates of July 1976 through December 1977 is long out of time and will not now be considered. The administrative action appealed from is DMAHS's setting of the final pre-CARE reimbursement rates, which took place on July 29, 1976. The latest arguable date would have been January 4, 1978, when the agency refused to increase those rates. This was more than two and a half years before the notice of appeal was filed. Because no administrative appeal process existed during the pre-CARE period, petitioner should have appealed directly to this court within 45 days. R. 2:4-1(b). See *Alberti v. Civil Service Com.*, 41 N.J. 147, 154 (1963). It did not do so. Accordingly petitioner's appeal from the rate period preceding January 1, 1978 is out of time and therefore is dismissed. [J.S. App. at 14a (emphasis supplied)].*

Appellant sought review of this dismissal by way of both notice of appeal and petition for certification to the Supreme Court of New Jersey. On October 24, 1983, the Supreme Court of New Jersey ordered the petition for certification denied and the appeal dismissed (J.S. App. at 8a to 9a).

ARGUMENT

Point I.

Since the dismissal of the case was based upon an adequate nonfederal basis and the federal question sought to be reviewed was not timely raised nor expressly passed on, the appeal should be dismissed.

Under the rules governing the practice of law in New Jersey, appeals from decisions or actions of state administrative agencies must be taken within 45 days from the date of service of the decision or notice of the action taken. N.J. Court Rules, R. 2:4-1(b). Due to the failure to comply with this rule, appellant's appeal of its per diem rates for the period between July 1, 1976 through December 31, 1977 was properly dismissed for failure to appeal within time.

By way of a letter dated July 29, 1976, appellant was notified of the "*final rates* established for your facility, effective July 1, 1976" (J.S. App. at 41a (emphasis supplied)). This notification was in keeping with the information provided by the State at a meeting with governmental facility representatives, including appellant's controller, whereby the facility representatives were informed that the rate established by the Bureau of Audits would be final. Thus, appellant had to appeal this final agency determination establishing its rate within 45 days of July 29, 1976. Since appellant did not file its appeal until November 17, 1980, the appeal of the rates for the July 1, 1976 to December 31, 1977 reimbursement period was correctly dismissed.

Furthermore, appellant's argument that it was awaiting an audit before appeal was properly considered and rejected by the Appellant Division.* In a prospective rate setting system, as is present here, the rates are not subject to upward adjustment due to a cost audit conducted at a later date. Rather, the audit is conducted to determine that (1) only proper cost items applicable to medicaid services were included and (2) those expenses claimed were reasonable. 42 C.F.R. §447.292(b) (3) (removed and revised 46 F.R. 47964 (Sept. 30, 1981)). Appellant was twice notified, by way of letters dated July 29, 1976 and January 4, 1978, of this purpose of the audit and that it would not establish per diem rates. Nevertheless, appellant failed to appeal prior to November 17, 1980.

Appellant can cite no valid reasons for its failure to appeal the rates set for the July 1, 1976 reimbursement period. Failure to appeal within the period prescribed by court or agency rule forever bars appellant from seeking further relief. See, *Alberti v. Civil Service Com.*, 41 N.J. 147, 154, 195 A.2d 297, 301 (1963). "Regardless of the degree of invalidity charged," appeal and review is subject to the prescribed time limitations. *Kent v. Borough of Mendham*, 111 N.J. Super. 67, 75, 267 A.2d 73, 77 (App. Div. 1970). Exceptions to the time limitations imposed by court rules, and by extension by agency regulations, for appeal and review should be "but exceptionally condoned,

*Since this allegation had been raised before the court below and rejected, appellant's request for a hearing under *Lopez v. Swyer*, 62 N.J. 267, 300 A.2d 573 (1973), is illogical (J.S.B. at 26). Appellant presents no new or different reasons for its failure to appeal than those previously presented to and rejected by the Appellate Division.

and only in the most persuasive circumstances." *Id.* 111 N.J. Super. at 76, 267 A.2d at 77.

It is axiomatic that the Supreme Court will not review State court decisions which rest on adequate nonfederal grounds. *Radio Station WOW v. Johnson*, 326 U.S. 120, 129 (1945). Failure to present a federal question in accordance with the State rules of procedure constitutes an adequate and independent nonfederal ground barring further review, unless the appellant were able to demonstrate that the State has no legitimate interest in enforcing the rule. *Michigan v. Tyler*, 436 U.S. 499, 512 n.7 (1978); *Henry v. Mississippi*, 379 U.S. 443, 447 (1965); see also, *Safeway Stores v. Oklahoma Grocers*, 360 U.S. 334, 342 n.7 (1959); *Cardinale v. Louisiana*, 394 U.S. 437, 438 (1969).

The barring of claims filed 2½ years out of time serves legitimate State purposes. First, it eliminates the necessity of the State courts being faced with stale claims growing out of long past transactions or occurrences for which witnesses or other evidence may not be available. Second, in a case such as this, the procedural limitation serves as a rule of repose serving the public's interest in a finding supporting the finality of the rate established on July 29, 1976 and the methodology utilized to set that rate. Utilizing the pre-CARE reasonable cost related methodology, LTCFs were reimbursed \$72,834,297 between July 1 and December 31, 1976 and \$150,852,981 for calendar year 1977 thus resulting in a grand total of \$233,687,278 in State and Federal reimbursement paid under this system. State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services, 1977 Medicaid

Annual Report. Not only is finality necessary to allow for the orderly governance of the regulated field, but verification of the services rendered or costs incurred by appellant and other nursing homes should these rates be reopened is exceedingly difficult, if not impossible.

Additionally, the State's, and by extension the taxpayers' of New Jersey, reliance on the finality of these rates is self-evident. By statute and constitution, Medicaid expenditures are limited to the amounts which were appropriated for each fiscal year. N.J.S.A. 30:4D-2; N.J. Const. Art. VIII, §II, par. 2.* Thus, no appropriations remain upon which to draw for reimbursement of appellant's claims. In like vein, the Federal taxpayers, who shared equally in the costs of reimbursing appellant and the other participating nursing homes during 1976 and 1977, have a similar legitimate economic interest in the dismissal of appellant's untimely claims in accordance with the general rules of practice of the State of New Jersey.

Without any doubt it rests with each State to prescribe the jurisdiction of its appellate courts, the mode and time of invoking that jurisdiction, and the rules of practice to be applied in its exercise; and the state law and practice in this regard are no less applicable when Federal rights are in controversy than when the case turns entirely upon questions of local or general law. When as here there can be no pretense that the State Court adopted its view in order to evade a constitutional issue, and the case has been decided upon grounds that have no relation to any federal question, this Court accepts the decision whether right or wrong. [*Wolfe v. State of North Carolina*, 364 U.S. 177, 195 (1960)(citations omitted)].

*"No money shall be drawn from the State Treasury but for appropriations made by law."

Here, the courts below analyzed the facts and circumstances surrounding the appeal of appellant's rates set by the pre-CARE system and found appellant's appeal to be "long out of time." Given the fact that the appeal was filed on November 17, 1980 from State agency action taken on July 29, 1976, this characterization of the appeal by the Appellate Division was obviously correct and was properly sustained by the Supreme Court of New Jersey. Since the dismissal of the case was based upon an adequate nonfederal ground of procedure, and the courts below never passed on the federal question, the Supreme Court should dismiss the matter for lack of jurisdiction.

Point II.

The Federal Question Raised Is Not Substantial.

The federal question raised in this case concerns the allegation by appellant that the method of reimbursing nursing homes in New Jersey between July 1, 1976 and December 31, 1977 was not in compliance with the federal requirements governing the Medicaid program. However, the State methodology was discarded on January 1, 1978. Similarly, the federal requirements, as noted previously, were changed on October 1, 1980 and the "reasonable cost related basis" requirement relied upon by appellant to form the federal question was eliminated prior to the institution of this suit. Pub.L. 96-499, §962, 94 Stat. 2599 (Eff. October 1, 1980). Thus the federal question concerning the compliance of the State of New Jersey with the federal requirements of Title XIX governing nursing home reimbursement was moot before the original appeal was filed. Hence, the dismissal of this moot claim as untimely gives rise to no substantial federal question requir-

ing review by this Court and the dismissal should be affirmed.

Moreover, the underlying claim for increased reimbursement raised by an individual nursing home against the single State agency administering the Medicaid program gives rise to no substantial federal question. There are no allegations of continuing noncompliance with Federal regulations or requirements. Hence, the Federal question, if one is considered to be raised, is in reality a request for damages presenting no substantial constitutional or other federal claim for which review is necessary. Therefore, the decision of the Supreme Court of New Jersey should be affirmed.

CONCLUSION

It is respectfully urged that for the foregoing reasons the appeal should be dismissed or, in the alternative, the judgment of the Supreme Court of New Jersey be affirmed.

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